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RESEARCH

Práticas em saúde mental na estratégia saúde da família: um estudo exploratório

Mental health practices in the family health strategy: an exploratory study

Prácticas en salud mental en la estrategia de salud de la familia: un estudio exploratorio

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ABSTRACT

Objective: Understanding the procedures, actions and approaches used in mental health in primary care. **Method:** a qualitative exploratory research developed with two teams from the Family Health Strategy in Juazeiro do Norte-CE, Brazil, between May and June 2009, with the non-participant observation and semi-structured interviews. The study was approved by the Research Ethics Committee of the Federal University of Ceará, CAAE N°16/09. **Results:** actions focused on mental health were shown to be related to the prescription of psychotropic drugs, the referral of cases to the clinic and home visits by community health workers. In the service, the Support Center for Family Health assumed a modest role, with individual consultations and few group activities. **Conclusion:** thus, it was observed in the practices of professionals from the Family Health Strategy the predominance of procedures for care under a reduced vision of health, focusing on the individual and on the injury, distinguishing from the proposals of collective and comprehensive care proposed by the community care model. **Descriptors:** Mental health, Primary health care, Community mental health services.

RESUMO

Objetivo: Conhecer os procedimentos, as ações e condutas adotadas em saúde mental no âmbito da atenção básica. **Método:** Pesquisa qualitativa exploratória desenvolvida com duas equipes da Estratégia de Saúde da Família, em Juazeiro do Norte–CE, entre maio e junho/2009, através da observação não participante e de entrevistas semiestruturadas. Estudo aprovado pelo CEP da UFC, CAAE N° 16/09. **Resultados:** As ações voltadas à saúde mental relacionam-se à prescrição de psicotrópicos, ao encaminhamento de casos ao ambulatório e às visitas domiciliárias realizadas pelos agentes comunitários de saúde. O Núcleo de Apoio à Saúde da Família assume papel tímido, com consultas individuais e poucas atividades em grupo. **Conclusão:** Observou-se nas práticas dos profissionais da Estratégia de Saúde da Família o predomínio de procedimentos de cuidado sob uma visão reduzida de saúde, com enfoque no indivíduo e no agravo, distinguindo-se das propostas de cuidado integral e coletivo conforme modelo de atenção comunitária. **Descritores:** Saúde mental, Atenção primária à saúde, Serviços comunitários de saúde mental.

RESUMEN

Objetivo: Conocer los procedimientos, acciones y conductas adoptadas en materia de salud mental en atención primaria. **Método:** investigación cualitativa, exploratoria desarrollada con equipos de la Estrategia de Salud Familiar en Juazeiro-CE, entre mayo y junio de 2009, por la observación no participante y entrevistas semiestructuradas. Este estudio fue aprobado por el CEP de la UFC, CAAE N ° 16/09. **Resultados:** las acciones relativas a la salud mental se mostraron a estar relacionadas con la prescripción de psicofármacos, la remisión de casos a la clínica para pacientes ambulatorios y las visitas de atención domiciliaria por parte de los trabajadores de salud comunitarios. El Centro de Apoyo a la Salud de la Familia participó tímida, con pocas consultas individuales y actividades grupales. **Conclusión:** observamos en las prácticas de los profesionales de la Estrategia de Salud de la Familia el predominio de los procedimientos para la atención en una disminución de la visión de la salud, con enfoque en el individuo y el daño, distinguiendo de las propuestas de atención colectiva e integral al ofrecido por el modelo de atención comunitaria. **Descriptores:** Salud mental, Salud primaria, Servicios de salud mental comunitarios.

Article derived from a Master's Dissertation "Culture circles in mental health: perspectives of teams of the Family Health Strategy", presented at the Postgraduate Program in Nursing of the Nursing Department of the Federal University of Ceará in November 2009.

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INTRODUCTION

The World Health Organization and the Pan American Health Organization have evidenced the primary care area as strategic for expertise in mental health, so as to contribute to demystifying of Stigmata, strengthening interpersonal relations and promoting health in an enlarged perspective.[1]

The current mental health policies, influenced by the psychiatric reform, have advocated a focused approach to assistance of inclusive character and rehabilitation through the insertion of individuals in their family relationships in the community and other social support networks, allowing paths that direct health promotion with emphasis on completeness.[2] For this, the centers of psychosocial care (CAPS) and the nuclei of support to family health (NASF) propose a work network for health service and support of demands in different levels of attention, offering aid to the primary care level.

In this context, the family health Strategy (FHS) shows up as reorganizing health relations service, insofar as it approaches the reality of life of subjects and, from it, directs new forms of acting, combining assistance and completeness, rescuing not only biological, but also psychological, social and cultural aspects, overlooking the complexity of the human being.[3]

Mental health is thus a work object of the family health team, in which expands possibilities for promotion, prevention of disease, health maintenance and rehabilitation, with a community network expanded. In view of this, the professionals involved must meet the local demands of mental health and from it propose interventions that incorporate users, families and community members.

Therefore, it is suggested to professionals acting in different spaces in order to promoting the link between the various actors imbued with this proposal, namely, users, health professionals, family, community, among others. Thus, the practices should be based on dialogue, allowing exchanges sensitive to the needs, according to the potential present in local reality.

Despite the efforts of mental health policies and services supplying temporary replacements, the practice in the family health strategy (FHS) still faces limits of operation of health teams, with actions directed to referral to specialized services, to illness and medication and few initiatives for the promotion of mental health. In this context, study proved that the FHS professionals are unsure in dealing with mental health and the assistance is performed so fragmented and under the priority in the sick, unweaving the training of individuals for care, reintegration and the discovery of social support networks.[4]

It should be noted, however, that the care for the person with mental illness by the teams of FHS integrates an unfamiliar scenario, and add to the difficulties faced by team members in the face of this attention. Thus, it is necessary investing in strategies that facilitate the strengthening and empowerment of these agents care for working effectively on mental health demands.

Thus, the study aimed to discuss with the social actors of the FHS the procedures, actions and conducts adopted in mental health in the framework of the basic attention. Furthermore, it was intended to providing referrals to increase expertise in mental health, with enhancement of autonomy and co-responsibility of the various subjects involved in the act of watching the other.

METHOD

Action research developed into two teams of the family health strategy, in the municipality of Juazeiro do Norte-CE, between May and June 2009. In this method, it has the previous diagnosis of life contexts and practices and, from them, are forwarded which manage interventions impact on living conditions.

In the study were made possible spaces for questioning and reflection with the purpose of providing a transformative action in reality. This transformation occurs by critics of the subject by their condition of being in the world and with each other, in co-responsibility and link relationships, rescuing the role of the individual within the collective.[5] Adopted as theoretical-methodological culture circles, proposed by Paulo Freire to health education.

Participated in the study 22 subjects; from these: doctors, nurses, technicians, administrative staff nurse, community health agents and academics of nursing and medicine involved in the service practices. The participation in the research occurred by the agreement on the inclusion in the study after prior meeting with all the professionals of the service for presentation of the proposed study, the relevance and objectives.

For data production, visits were made to the service, using as a technique for collecting information to non-participant observation, followed by journaling field. Concomitantly, there was application of semi-structured interviews, recorded on a digital recorder in order to emphasize the aspects of mental health service and in the present times of circles of conversation among the study participants. Data analysis was by listening, transcribing and exhaustive reading of speech, followed by the categorization according to content similarity and triangulation of methods, ie, through the content of the interviews and records in a field diary. This step has been generated the following categories: characteristics of mental health assistance: priority in the use of psychotropics and referrals; performance in the core for support to family health and Psychosocial Attention Center in the basic attention and the demands of training on mental health in the FHS.

The study was submitted prior to the Research Ethics Committee of the Federal University of Ceará, with CAAE In 16/09. There were subject to the ethical aspects of the resolution 466/1012, of the National Council of Health/Ministry of Health, which directs the rules for research involving humans. In contact with the participants, there were elucidated the goals and benefits of this research. After clear all doubts, the participants signed the

terms of free and informed consent. In the presentation of results, have opted to identify subjects by the consonant P, followed by ordinal number (P1, P2, P3, and P22).

RESULTS E DISCUSSION

Characteristics of mental health assistance: priority in the use of Psychotropics and in the referrals

In the opinion of the participants of the study, the use of psychotropic drugs in the elderly population exacerbated and those who have signs of mental distress indicates a serious problem. Related to this, participants 9 and 21 reported the use of psychotropic drugs as one of the main demands with difficult and management approach.

> The use of psychotropic drugs by patients, they take a lot. In my area which covers most is the use of psychotropic substances. (P9).
>
> [...] some patients, exactly those who want to continue taking the medication and the doctor doesn't want to prescribe or want me to stay in a situation more smoothly, and they don't want to understand. Perhaps because they are already dependent on medication [...]. (P21).

Still about the actions implemented in mental health services, some speeches indicated that the conduct adopted followed a trend with the prioritization of biologicist referrals to specialized interventions. These, by the great demand and consequent execution by professionals, originate from user access barriers by overcrowding of the specialized services, which represents a break in the continuity of care. The emphasis on specialized actions occurs, therefore, disjointed manner of the social and cultural context, exerting little impact on the conditions and quality of life of individuals.

> Because the nurse and the doctor they visualize the physical, they seek the necessary treatment and sometimes there's no way and if I had the specialized professional for this area of mental health, he could already identify and could work together. (P4).
>
> If a person says that has need of treatment or if I check, if I can identify, we first forwards to the doctor to do the forwarding to the psychologist or to other specialized professional. (P10).
>
> Adequate attention has not so specifically. Because it is as I told you, I don't have an expert and it's hard, because often the patient arrives and seeks attention and has no. (P15).

In this perspective, the practices in the FHS have emphasized the use of actions of curativist and individual approach, based on the specialty of the attendances of drug base, moving away from the other perspectives that contemplate interventions such as promotion and prevention of diseases.

Performance of the core for support family health and Psychosocial Attention Center in the basic attention

In the scenario of the basic attention, the nuclei for support to family health (NASF) enable teams of FHS support to various demands of health, included in the mental health. In reality, the NASF assumes the function of assisting the individual and collective cases of mental distress, in particular the professional psychologist.

> It strengthened further with the coming of NASF this work because today we see that now come more people. People are not coming just to get the prescription, but rather to be accompanied by her. (P3).

> [...] has the NASF team, which is committed to the FHS, on primary health care, which has a psychologist who treats this kind of disease. She makes an approach, she has specific treatment groups. (P8).

The speeches of participants 3 and 8 deposited in NASF the possibility of specialized attention for mental illness at the basic level of attention, which becomes reference to meeting this customer base, establishing a space given to "treat this type of illness", as it strengthens the participant 8. For it the referrals become constant practices and the handling of situations where mental health by FHS team reveals itself increasingly scarce, considering that the specialized professionals are elected to host this clientele.

To cover the integrality, health systems must rely on services at all levels of assistance to ensuring the longitude and continuing attention. On the network of mental health services, Day-care centres (CAPS) are responsible for receiving the demands and guiding the actions on all levels of attention, keeping the reference and counterreference cases. Despite the stated, the professionals have little approximation or ignorance about the potential performance of this service and the possible articulation of FHS teams with day-care centres (CAPS).

> At the very beginning informed us that patients were being referred to there, but in my area even has no case of a patient to go to the CAPS. Thus, a vacancy, a gap for me to know directly so how does CAPS, because I still have not had experience. (P6).

> I've lived here for 18 years and I don't know where the CAPS, I don't know how the work, do not know what their proposition, I don't know how the attendance, and how something that is not much talked about, is not widely circulated, so you end up not just me, but I believe that most of the team doesn't meet that kind of answer to say:-Oh, I know the place where it makes the specific treatment. (P21).

It was evidenced in the speeches of participants 6 and 21 ignorance as to the actions of CAPS in face of mental health demands and its role as regulator of the assistance network. Thus, assistance to clientele who demand this type of care is fragile, what represents us break ties which realization between the service and the community.

Mental health training demands in FHS

For the FHS professionals can adequately perform before the demands, it appears necessary to the work of continuing education through the introduction of support teams that provide moments of sharing knowledge and support before the cases that emerge from daily practices. It recognized the urgent need for training of health professionals so that they can accommodate the demands on mental health and know the ways of coping before facing the front. Fact highlighted in the speeches of participants 11 and 17.

> If you had training for people better understand to better address the patient too. In the case of mental health, we just question if you take medicine for mental problem? And he answers:-Take, take for sleep. Ready then, stopped our involvement. We don't have any more to offer, and to charge the patient also. (P11).
>
> Training for us to have more knowledge about the subject, so when we did visit, in our visits we had more resources to talk to the family, how to deal with that patient. (P17).
>
> What we see less, or what is less charged, we don't care much. (P21).

There are reports by participants 11 and 17 of little or no preparation to watch and forward the person in mental distress in the community. The professionals exhibit limits for competent performance in the face of possible working tools present in the space of basic care and restrict their demands for health actions advocated by FHS programmes, abandoning those relating to the promotion of mental health, said the 21 participant.

Despite the proposed modifications in mental health practices, patented in the scenario of the basic attention the persistence of exclusivity on the use of pharmacological treatment for issues involving the psychic component. This conduct takes out from context aspects of people's lives. The power to recognize and point out the measures for the assistance becomes a priority to professional of psy, despising the tools present in the local context, which may represent gains for the individual in suffering, the family and the community that involve.

Even if there is such a situation in practice, the literature points to the investment in actions that aim for completeness and to group the psychosocial aspects. These are new ways to cope in the face of mental distress and impact on quality of life of the subject. Thus, the use of psychotropic drugs is just one of the countless options of acting, going on other devices with emphasis in the bond, in rehab, in the rescue of autonomy and participation of people as subjects.[6]

Thereby, health professionals linked to the basic care should be supported so that they have means of implementing these practices and move to other next to what is offered in the community space, strengthening the links between what is proper and what culture is the field of science.

Despite the changes to the integral attention to health, advocated by the benchmarks proposed by the National Policy of Health Promotion, including biological components, cultural, social, psychological and persists the dichotomic view between body and mind, fragmenting the audience and removing from primary care intervention possibilities.[7]

Units of FHS of this study prioritized interventions about illness, translated into signs and physical symptoms. Part of this stems from the vocational training model that emphasizes a biomedical health design, characterized by a focus on disease and body at the expense of other instances of life. The individual is seen as an intervention object and an owner of knowledge which nullifies other forms of knowledge, such as the popular and cultural. As a result, the FHS reveals difficulties of monitoring of the specific actions with the mental suffering of the people in the community, opting for referrals.

However, the difficulties of FHS are recognized, of which they propose on the network teaming matrix support for demand appropriate assistance in mental health. The support team provide to FHS professionals guidance and support regarding the management of local health needs, considering the available resources in this context, leveraging the capabilities of performance at the primary level.[8]

In the context of the matrix support, the NASF were created in January 2008, by Ordinance No. 154/2008, instituting the comprehensiveness of assistance to users of the unified health system (SUS) through the qualification and complementarity of the work of the FHS. Proposes an integrated way of working with the network of health services from the demands identified in joint work with the basic attention.[9]

One of the roles of NASF is to contributing with the teams of FHS, local health councils and communities, in the definition and diagnosis of the main health needs in a given territory.[10] Still, reinforcing this responsibility, it is believed that NASF, in the context of mental health, arises as a potentiator of actions in the field of basic attention. Yes, represent additional tools to the CAPS to the deal before the demands of mental suffering.

NASF incorporates several professionals of different modes of knowledge in order to providing support through training activities and permanent education, help in group work, consultation liaison, among other practices that promote the autonomy and empowerment of staff to deal with everyday situations, thus avoiding unnecessary escalations and the accompanying disruption. One of these areas of expertise covers the field of mental health, allowing the growth of networks of expertise linked to the territory.[11]

Although the current national policy on mental health direct about the increased attention network and the role of articulator CAPS among health services at all levels of attention, see inaccuracies in the relations established between the reference service in mental health and, in this case, the basic health units.

It becomes necessary integrating the health network for providing customers the appropriate directions and assist the public in understanding the care that will be offered in other levels of attention. The CAPS, as articulators of expertise in mental health, assumes co-responsibility of different levels of attention. In the field of primary health care, these services must facilitate spaces for expression of mental illness, contributing to break limits given by stigmata.[12]

Although there are no still biggest actions in the sense of expanding the space for performance in mental health, this was included in the Pact for Life in 2008 as one of the priority areas of intervention in the basic attention. In view of this, it is necessary to combine efforts to ensure the implementation of these proposals, being one of the

possibilities the incorporation of mental health indicators that allow the understanding of the Situational diagnosis and thus direct the practices to be implemented.

The incentive processing practices are part of the national policy of primary health care as a means to enable people to cope better with the demands met, representing gains in quality of life and well-being of these individuals.[13]

In the case of mental health, it is essential to raising awareness of the team to be allowed to occupy a positive learning environment, with the development of personal skills generating increment in the potential for interventions that have major impacts. Such approaches mean strengthening the ability of performance from the territory, combining the user, family, neighborhood associations and other local devices with regard to the control and management of medication, to ways to establish relationships with these people, to strategies for reinsertion representing increment in quality of life of people in mental distress.[14-15]

IMPLICATIONS FOR PRACTICE

The work in health imposes a series of challenges for which the professionals are not prepared. The proposal of integral attention to health puts health professionals in conflict situations, since it must accommodate demands for which were not aware or prepared, feeding the dichotomy between the watch and the proposed lack of integral conditions for implementation of such project.

Mental health is one of those areas that reveals health workers' resistances ranging from existing stigma by society for suffering or mental illness, but also the complexity of dealing with the subjective. Part of this stems from vocational training, focused on specialties, expressing signs and symptoms so aim for the determination of the actions of resolution of cases.[16-17]

When dealing with aspects of mental health, it is necessary the development of other components, including the bug, the link and the host, in order to meet the needs of customers and allow spaces for expression of feelings, perceptions and expectations. For this, it is important to incorporate, in health practices; new technologies of care able to accommodate the complexity of relations between individuals, not limited to the diagnosis and physical aspect, but proposing new ways to cope that allow the understanding of the context of the lives of individuals within the formal and informal care networks.

CONCLUSION

The Family Health Strategy is an appropriate space for mental health practices, as it provides care with an emphasis on family, from the perspective of integrality, universality and equity of care. Thus, as advocated by the Unified Health System, the service is placed closest to the community and the health determinants interwoven the territorial bases must

be restored, and the interdisciplinarity of the practices, which allows for greater acceptance of the demand.

On Basic Health Unit under study, there was the ID that the actions directed to mental health were related to an act strictly in the forwards and biologicist possibilities of a do on mental health. In parallel, the ignorance of the network functionality of attention in mental health was predominant, contributing to the disarticulation between the different levels and assistance services, representing rupture in continuity of access and the impairment of quality of the service provided.

In this perspective, urges awareness of FHS professionals regarding the incorporation of other pipelines in the mental health act, establishing new relations with the context of people's lives. Because, besides of the disease, the search for understanding of the determinants that affect the conditions of existence of individuals and to quality of life or not. Thus, the FHS did not restrict its actions only to the field of assistance aimed at the treatment and rehabilitation of diseases, but also and primarily should insert in the practices actions for the promotion of health and prevention of diseases.

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